

DYAD ART THERAPY: BIRTH OF A MODALITY

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ABSTRACT

DYAD ART THERAPY: BIRTH OF A MODALITY

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This project investigates the early development of dyad art therapy and the publications leading to its birth and subsequent consolidation as a modality. Dyad art therapy is an intervention method whereby the caregiver and the child are both simultaneously involved in the therapeutic process by means of art making or art exploration. This modality harnesses the creative process in order to address and work through issues relative to the parent-child relationship. Dyad art therapy is an emerging format of intervention showing a recent increase of use in practice (Taylor Buck, Dent-Brown & Parry, 2013) and visibility as witnessed by publications. This research project highlights certain characteristics proper to the dyadic format and situates the development of the modality within a larger theoretical context, notably the seminal roots of family therapy, Object Relations, Attachment Theory, and mother-child matrix theories.

A review of art therapy literature, enhanced by interviews with experienced dyad art therapists, serves to retrace the early development of parent-child therapeutic work from the 1970s through its gradual evolution until the birth of dyad art therapy as a modality in its own right at the turn of the century. The author presents dyad art therapy contributors who independently developed methods of working concurrently with parent and child. Notably, the work of Lucille Proulx (2003), with the first comprehensive model of dyadic art therapy, was determinant in launching the affirmation of the modality and initiating the beginning of the present period of consolidation.

Keywords: art therapy, dyad, parent child, mother child, caregiver child, mother infant, , family therapy, attachment, dyadic intervention.

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Introduction

Through my years of training in art therapy (first in a certificate program at the Universidad de Chile, then in the Creative Arts Therapies Master's program at Concordia University), dyad art therapy gradually became a pillar of my professional identity. My evolution is not unlike the journey of some of the dyad art therapists presented in this project who intuitively came to use the modality through a combination of notions learned from their personal and professional lives. My own gravitation towards working with the parent-child dyad was initially ignited by my dyadic experiences with my first child. I was immersed in a dyadic world and fondly remember our art making activities and the liberating, magical, and emotionally intense dance printed onto the paper.

Throughout my experience as an art therapy student, dyad art therapy was mentioned in passing as it seems to be the case in other training programs. Such that working with a dyad may not have seemed like a real option had not met Lucille Proulx in Chile in 2009. Learning about Proulx's (2003, 2004) parent-child-dyad art therapy methods influenced the realm of my improvised art activities with my son and broadened my developing concepts as an art therapist. For me, it was as if a bridge that had always been present was suddenly visible and now brightly lit. This enlightenment was a pivotal moment.

As I entered the Master's program at Concordia, I had the unrealistic expectation of being able to satisfy my thirst for knowledge and drive for further experiences in dyadic intervention. After all, Lucille Proulx was trained in the same program and developed her methods in Montreal. Later, I came to realize that dyad art therapy is barely covered in professional training programs worldwide, and practicum placements that offer the opportunity for focused supervision and practice in dyad art therapy are limited. My initial literature review revealed to also be limited and scattered in providing information in dyad art therapy.

Yet my experiences with dyad had *felt* different than that with others clients. My adaptation of more mainstream art therapy guidelines felt uncomfortable to me; things didn't seem to fit. Stern's (1995) words ring true to these impressions: dyad therapy "is not a compromised normal clinical situation. It is a different clinical situation, with its own imperatives and opportunities. It must be seen on its own terms, not as an imperfect or pale application of another established therapy" (p. 17).

I also began to feel isolated: Where were the art therapists who are working with dyads? I could not conceive that the lack of coverage could be representative of practicing art therapists. Were they just not writing? My desire to further my professional training and search for mentors and colleagues in dyad art therapy fueled this culminating project. This research project was born from a process of searching for information, professional training, and developing an expertise in dyad interventions and early childhood.

While I had initially planned to compile information from the existing literature and from practicing dyadic art therapists, my focus changed when I realized that dyadic art therapy was in the midst of a rapid expansion, and some art therapists (Taylor Buck et al. 2013; Taylor Buck, Dent-Brown, Parry & Boote 2014; Regev & Snir, 2014, 2015) were already conducting research to propose answers to many of my nagging questions: Who is using dyad art therapy? How and why is it being practiced?

While it was invigorating to find that dyadic art therapy was alive, thriving, and in process of consolidation, my feelings of isolation were not completely eliminated. I was unfortunately geographically distanced from the loci of development mostly in Great Britain and Israel. Furthermore, the dyadic art therapy development centered in Montreal led by Lucille Proulx a decade earlier had seemingly become dormant¹. It became increasingly clear to me that my contribution was to focus on the early development of dyadic art therapy and understand the theoretical and historical context which led to Proulx's (2002, 2003) affirmation of dyadic art therapy as a modality. In other words: How did dyadic art therapy come to be? And what has influenced, characterized, and defined this modality along the way?

Thus I set out to gather what documentation already existed, and from there to extract underlying theory, practical tendencies, and historical context from which dyad art therapy can be more deeply understood. This paper presents a review of early dyadic art therapy interventions published by North American authors before dyad art therapy was presented as a modality. I have striven to accomplish an exhaustive literature review of material in the English language by art therapists published in books and official art therapy journals (see Appendix: Dyad art therapy readings). However, accessing material from early development period of the field of art therapy, combined with the multitude of different terms used to designate the dyad

and dyadic art intervention, have proved to be beyond the reach of a Master's level research essay, and I cannot completely assure the reader that I have in fact found all pertinent literature written in English².

Throughout the process of writing this essay, it has come to my attention that my approach is inevitably influenced by my professional training and Western cultural background. This has particular impact in the chapter pertaining to theoretical grounding of dyadic therapy. My undergraduate studies in Sociology have influenced my understanding of the dyad and family as relational systems. Likewise, the psychodynamic orientation of the trainings I pursued in art therapy (both in Chile and in Canada) has also impacted my perspective of the dyad seen as the primordial unit defined by the intrapsychic communications. While the literature reviewed pertaining to dyadic interventions confirms the importance of family therapy and psychodynamic theory, my personal biases may have enhanced the voice of these schools of thought over those of other theoretical perspectives.

Despite the practical limitations of reviewed literature and my personal biases as researcher, I believe that the material gathered sheds new light and provides a more comprehensive understanding of the development of some aspects of the practice of art therapy. Ultimately, with this project I hope to contribute a useful tool in understanding dyadic art interventions.

After a preliminary guide to the terminology and vocabulary pertinent to this paper, I will offer a brief portrait of dyad art therapy as an emerging form of intervention and contemporary modality. I will then situate dyad art therapy within a theoretical frame and explicate tendencies in practice, informed and fed by various sources. In many ways this modality diverges from the more common stream art therapy practice. I will here outline dyadic therapy's characterizing elements. I will then turn to the development of dyadic art therapy as described in the published literature, concentrating on the early development in North America to the affirmation of dyadic art therapy as an independent modality. In the Appendix, I have included a list of the literature

¹ It should be noted that I later learned that some art therapists such as Francine Nadeau (F. Francine, personal communication, July 17, 2014) were regularly practicing dyad art therapy in Montreal but have not published about their experience.

² Pertinent material also exists in French and Hebrew, and probably in other languages as well. Furthermore, extending the search to include MA and PhD theses, and conference papers would most likely add a rich array of perspectives and experiences.

on dyad art therapy as a reference for those interested in further reading in the contemporary and rapidly growing modality.

Terminology and vocabulary.

Before proceeding further, it is necessary to specify use of various elements of terminology and vocabulary relevant to this research project.

The parental figure. As the adult component of the dyad, the term caregiver (used in North America) or carer (used in Great Britain and Israel) is the most inclusive term. However, *mother* is most commonly used in the reviewed literature, corresponding to the mother being most common caregiver of a child. *Parent, primary caregiver or carer, father, and grandmother* are also sometimes used. In this paper, I will use several of these terms, but what I am referring to is the primary caregiver of the child, whoever this may be, regardless of biological relatedness to the child, gender, or permanency of the relationship with the child.

The dyad. In the art therapy literature reviewed for this paper, many terms are used to describe a dyad and a dyadic intervention. In the early literature on dyadic art therapy, *mother-child pair* (Landgarten, 1975) and *joint mother-child* (Rubin, 1974a, 1974b, 1976, 1978) are examples used. As the modality developed, the term dyad was increasingly used, but not all contemporary authors use this term. I will usually use dyad except when referring to a particular author's preferred term.

The dyadic intervention. Similarly, there are variations in terminology referring to an intervention that focusses on a dyad. Before dyad art therapy was considered to be a specific modality, many terms were used such as *mother-daughter group art therapy* (Landgarten, 1975), *joint mother-child session* (Rubin, 1974a, 1974b, 1976, 1978), or *single-mother family art therapy session* (Rubin, 1976, 1978). Contemporary literature has not reached consensus here either: in Great Britain *dyadic art psychotherapy* is the generally preferred term whereas *dyad art therapy* is preferred in North America, with exceptions in the cases of specific methods developed, such as Proulx's (2003) *parent-child-dyad art therapy*. In Israel, the preferred term is *parent-child art psychotherapy* in reference to the method developed by Ben-Aaron, Harel, Kaplan and Patt (2000). I will usually use *dyad* or *dyadic art therapy* as a generic terms but tend to use the author's preferred term when referring to a specific method.

Art therapy versus art psychotherapy. The use of one term rather than the other implies issues rooted in geographical, conceptual, and training differences. This is also a historical professional dilemma of the field that I will not address in this paper³. Throughout this paper, I will use *art therapy* in its broader encompassing meaning, but *art psychotherapy* is common throughout this paper as commonly used by authors who are cited and discussed.

What is dyad art therapy?

Before addressing the theoretical grounding of dyadic interventions and retracing the emergence of dyadic art therapy, it is first necessary to give a brief portrait of the modality as practiced today.

Defining the dyad

The broad definition of dyad refers to “something that consists of two elements or parts” (*New Oxford American Dictionary*, 2010); it is used as a technical term in areas such as mathematics, chemistry, and psychology. The term dyad appears straightforward: it refers to a structural aspect of something composed of two entities. In the context of therapy, a dyadic intervention refers to an intervention where there are two individual persons present with the therapist. The term dyadic therapy can be used to describe an intervention with any two people in a relationship, but the manner in which dyadic therapy is most commonly used is in reference to a relational unit composed of a child and a parental figure.

The dyadic art therapy session

While concepts and theoretical grounding presented in this paper will contribute to giving a more in-depth understanding of dyadic interventions, first I will present an overview of what dyad art therapy is in practice. The research conducted by Taylor Buck et al. (2013, 2014) and Regev and Snir (2014, 2015) will likely soon provide a more comprehensive definition of dyad art therapy. In the meantime, there are many specific dyadic art therapy methods developed by individual art therapists, but still little definition of the modality itself. It is within this context of a multiplicity of examples that I strive to paint a broad portrait of dyadic art therapy.

A dyadic intervention “directly involves the parent or carer in the therapeutic work alongside the child” (Taylor Buck et al., 2013, p.26); in this setup, the parent is not only part of

³ For a discussion regarding the implication of the terms art therapy and art psychotherapy, I suggest consulting articles “Art Therapy: Problems of definition” (Ulman, 1992).

the client unit but also potentially part of the acting therapeutic intervention. In dyad art therapy, the therapists invites the parent-child encounter (their interaction, communication, and relationship) to be played out in art making. For the art therapists who choose to use a dyadic format, there is an embedded belief that the creative process not only influences the parent-child interaction but “plays an important role in the treatment outcome” (Plante & Bernèche, 2008, p.21). Despite this, Regev and Snir’s (2015) research on dyadic art therapy reveals that “only scant literature... has dealt with ways to incorporate art materials into clinical work and the translation of therapeutic objectives in art therapy” (p.51).

While art is not the sole mode of interaction within the caregiver-child unit during a dyad art therapy session, it is the proffered context of interaction and holding. Hosea (2006) refers to co-creations and moments of meeting which enable a different way for parent and child to be together. This activity is considered by Arroyo and Fowler (2013) as a “potential space... [Winnicott, 1971] developed between mother and infant where they are [in a] relaxed state of creative play, and where meaningful symbolic communication occurs through shared experience” (Arroyo & Fowler, 2013, p.102). Also grounded in Winnicott’s theory, Shore (2000) explains: “the child’s creativity is channeled into therapeutic expression, which helps to illuminate evidence of both internalized conflict and strengths in the parent-child bond... the therapists can use all this information to strengthen the parent and the parent-child bond, while the child’s creative potential is used to organize and work through conflicts” (p.15).

The common ground seems to be that the art making activity becomes an opportunity for relational intimacy and a facilitator of meaningful communication between both members of the dyad. Regev and Snir (2014) write: “Parent and child are involved in a visual creative experience that uses imagination and enables symbolic, non-verbal expression while the two engage in an artistic activity carried out jointly according to the child’s developmental level” (p.511). Plante and Bernèche (2008) point out that this symbolic aspect differentiates art expression from other forms of pleasurable play and games. Here, the “symbolic dimension to the interaction [is] an important component to each participant’s re-discovery of --and increased responsiveness to-- the subjective experience of the other” (p.22), and the art creation can also become a tangible symbol of the parent-child encounter (Hosea, 2006; Proulx, 2003).

While the therapeutic use of art (to differentiate it from a recreational or educational use) is set up in different ways for different dyad art therapists, there is particular emphasis on

containment as essential in order to permit the dyad's safe engagement in the creative process. Hosea (2006) writes: "The containment of the mess is an important function of the art therapist... the containment is pragmatic and physical as well as psychological (Bion, 1962) and allows the mother and child to have a safe, expressive space where they can play freely, build up a sense of themselves and experience feelings of connectedness" (p.76). This containment can take various forms within the art making activity. For Proulx (2003), the containment is symbolically offered by the paper on which the dyad work together; for Hall (2008), the containment is delimited by the floor space on which the dyad engages in art making.

Within the general guidelines of dyad art therapy, art therapists have developed different manners of putting these into practice, adjusting to the development age of the child, the specific needs of the dyad client, the type of setting, as well as the theoretical grounding used by the therapist. The author, Lucille Proulx (2002, 2003), most explicitly explained her dyadic art therapy methods and has also provided audio-visual demonstrations (2004, 2005). In Proulx's *parent-child-dyad* art therapy, "the parent is encouraged to interact simultaneously and in the same language with the child by creating art on the same paper as the child. The intervention is based on Attachment and Functional Emotional Theories" (L. Proulx, personal communication, March 28, 2016). For Proulx, a defining aspect of her method is that both the parent and the child make art on the same contained physical space (the paper or another art making surface) and in the developmental creative language of the child (Proulx, 2003).

Contemporary Dyad art therapy

There are strong reasons to believe that dyadic art therapy practice is presently thriving: it "appears to be an important emerging practice" (Taylor Buck et al., 2013, p.20). Taylor Buck et al.'s (2013) survey findings reveal that "in the wider population of [British] art therapists working with children and young people, the... percentage of those who include parents and carers [in therapeutic treatment] lies somewhere between 50 and 70 %" (Taylor Buck et al., 2013, p.26). In comparison to a survey carried out in 1999 by Karkou (1999) that focused on the practice of creative art therapies in elementary schools, these new results "suggest a rapidly evolving landscape" (Taylor Buck et al., 2013, p.20).

In the last 12 years⁴, published dyad art therapy literature has dramatically increased; it now presents an active array of research endeavours and intervention models. The work of these art therapists, as both clinicians and researchers, are testimonies to the extended geographical reach and vast dyadic experience in North America (Shore, 2000, 2014; Plante & Bernèche, 2008; Henley, 2005, 2007), Great Britain (Arroyo & Fowler, 2013; Hosea, 2006; Hall, 2008), and Israel (Gavron, 2013, Gavron & Mayseless, 2015; Regev & Snir, 2014, 2015; Markman Zinemanas, 2015); as well as Asia (Lai, 2011; Shin, Choi & Park, 2015). This multi-national literature is also interesting regarding the variety of adaptations of dyadic interventions to the cultural differences that influence parent-child relations.

Several art therapists have explored the dyad's experience of engaging in art making together within the therapy setting (Hosea, 2006; Shin et al., 2015), the impact on the parent-child dynamic (Plante & Bernèche, 2008), and the development of dyadic art assessment (Gavron, 2013; Gavron & Mayseless, 2015). Dyad art therapy authors also cover interventions with clients presenting a variety of difficulties such as mothers' depression (Arroyo & Fowler, 2013), domestic violence (Lai, 2011), trauma (Markman Zinemanas, 2015; Shore, 2014), reactive attachment disorder and adoption (Henley, 2005, 2007), sexual abuse (Ambridge, 2001), and separation-individuation difficulties (Siegle, 2011).

Perhaps the most relevant testimony to the affirmation of dyad art therapy as a modality in its own right is provided by art therapists who are investigating its use. Research lead by art therapist Taylor Buck et al. (2013, 2014) in Great Britain and creative art therapists Regev and Snir (2014, 2015) in Israel sets out to "test the hypothesis that practicing art psychotherapists are adopting a dyadic approach" (Taylor Buck et al., 2013, p.21) and to respond to the "gap between the extensive knowledge that exists in clinical practice and the literature" (Regev & Snir, 2015, p.50). Both research endeavors are currently gathering more information, addressing the consolidation of dyadic art therapy and engaged in "seek[ing] consensus on the core therapeutic principles, practices, and competences required for the delivery of dyadic art psychotherapy" (Taylor Buck et al., 2014, p.163).

In response to this strong development and growing interest, there are indications that training for art therapists may need to include more information and experience regarding dyadic

⁴ The period prior to 2003 and the choice of this year as a marker in the development of dyad art therapy will be discussed in this paper.

work. The British Association of Art Therapists (BAAT) is following suit: it offers professional training courses on dyadic art therapy and on the inclusion of parents and carers in educational setting interventions.

Situating dyad therapy in theory

The development of dyad art therapy was pioneered from various theoretical and practical perspectives. It is therefore important to present the schools of theory and practice from which dyad art therapy is grounded and from which it evolved. My goal at continuation is not to pin-point dyadic therapy's theoretical beginnings but rather to highlight the different seminal soils in which dyadic therapy has found nourishment, permitting its evolution.

Regev and Snir (2014) write: "The main tenet of [dyadic] therapeutic approach is the parental role in a child's emotional development and the assumption that the individual grows within and through relationships with others" (p.511). This notion is common to family therapy, Attachment Theory, Object Relations, and mother-infant matrix theories. I will present each of these theoretical groundings by focusing on certain authors selected from the most commonly mentioned references in dyad art therapy literature.

Throughout this chapter, it is also important to keep in mind that these are not mutually exclusive categories but rather the concepts coexist and overlap. For example, Donald Winnicott's theoretical contributions are commonly linked with the Object Relations model; however, his conception of the mother-child relation is a tenet of Attachment Theory and his infant consultation methods can also be seen as a form of family therapy⁵. Parashak (2008) further notes:

Winnicott (1971) advocates important ideas about early relationships that have contributed to family therapy. There was a shift with Winnicott's work in the understanding of the human being that went from a "one to a two person psychology" and offered a foundation for Object Relations. This explains why we examine the mother-infant dyad and try to understand the growth and responses of mother and child within this system. A systemic look begins with the mother-infant interaction and attachment outcomes and closely aligns with contemporary family therapy systems model. (p. 75).

⁵ For more information regarding parallels between Winnicott's *parent consultation* and art therapy with children, I suggest reading Shore (2000).

Family therapy

Family therapy is a branch of psychotherapy that works with families and individuals involved in intimate relationships. Within a short time period in the mid-20th century, family therapy evolved into many different schools. Instead of being centered on one theory, approach or author, family therapy developed simultaneously from many thinkers from eclectic backgrounds (Hoshino & Cameron, 2008). As the art therapists who paved the way as family art therapists tended not to join any one particular school and “art in and of itself was the theoretical lens through which family stories, dynamics, and structural characteristics came to life” (Hoshino, 2008a, p. 39-40), I will not describe the different characteristics and influences of the many branches of family therapy. I will, however, review key notions from family therapy that are relevant to dyad art therapy as a specific mode of intervention⁶.

Despite the heterogeneous, multidisciplinary aspects of the emerging school of family therapy, the early movements all evolved in defiance of the status quo of psychotherapy of the time, shifting the focus from the individual to the systemic, from the past to the present, and from the initial cause of an issue to the enactment and persistence of the problematic (Hoshino, 2008a). In contrast, psychoanalysis had posited that it was generally counterproductive and even dangerous for the therapist to treat more than one member of a family (Hoshino, 2008a) and was traditionally more interested in internal mental life than real-life relations (Sobol & Williams, 2001).

Regev and Snir (2015) point out that psychotherapy began with the adult patient and the “treatment of children was based on the individual therapy model that derived from individual-oriented psycho-dynamic concepts (Freud, 1927; Klein, 1932)” (p.50). The development of family therapy was based on the notion that “family is a significant unit that must be addressed when observing and treating the individual” (Regev & Snir, 2015, p.50); this position in turn initiated substantial changes in the treatment of children.

Family therapists believed that involving more than one member of the family can benefit not only the client but other family members and the entire system as well. At the root of the change from individual therapy to family therapy is the conception that individual difficulties do

⁶ For a comprehensive perspective on the development of schools of family therapy and family art therapy, I suggest consulting the chapter “The development of family therapy and family art therapy” (Hoshino, 2008a).

not happen in isolation but rather within the different systems and sub-systems (family, culture, society, etc.) of which each person is a member. Hoshino (2008a) writes:

The systemic perspective profoundly impacted on the conceptualization of human problems and the understanding of behavior... because elements... are intricately linked to one another, [and] one's action influences and is, in turn influenced by the action of the other... [and] each element's action has an impact on other elements and on the system itself. (p. 27)

The family is thus seen as a complex web of relationships and active dynamics between all members, in addition to the sum of the individual people that are participants in this network. Consequently, "family therapy... deviates from individual therapy by shifting its emphasis from the 'why' to the 'what' of human behavior" (Hoshino, 2008a, p. 27) and the therapeutic work with the material that takes place in the here-and-now. It is not that the origin of the problem is dismissed in family therapy; on the contrary, digging deep into the root of the issue is often part of the process, especially in family of origins work. However, the main focus is identifying how the problem persists and altering the context which permits a problem to persist: in family therapy, improvement does not occur through historical search for the problem but rather through changing the present system which maintains and feeds it. In Hoshino's (2008a) words: "the goal of family therapy is to understand the context, identify the patterns within the context that is sustaining the problem, and finally change the context so as to alleviate or eliminate the problem" (p.27).

In therapy, the family also differs from a group. On the one hand, the members are not linked by their stage in life, interest, common symptom or contextual adjustment: they are in a way a very heteroclite group with sometimes opposing interests, goals and needs. On the other hand, the members of a family have been together for many years (since birth for some) and "through the years have developed their own interactional pattern and a... interlinked system of defenses... with their own patterns of thinking [all which contribute in producing] the special culture or climate" (Kwiatkowska, 1962, p.4).

The dyad is undeniably one of the many possible configurations of family, and thus dyad therapy may seem to logically belong within the model of family therapy. Taylor Buck et al. (2014) write: "there is significant overlap between dyadic parent-child art therapy and systemic family art therapy, and in some instances (for example a single parent with only one child) it

could be argued to be one and the same thing” (p. 164). While dyadic and family modalities share many commonalities, Rubin (2005) clarifies that, in practice, family art therapy “can and usually does involve the entire nuclear family,” while dyad art therapy works “with smaller components of the larger unit” (p.188). In family therapy, the treatment of the dyad is usually by default instead of by choice.

Yet the concept of dyad as a structure is derived from a systemic view; it is difficult to fully take into account the depth of the caregiver-child unit as an interdependent, emotional and physical connection without a general systemic perspective. If the structural aspect intrinsic to family therapy is not integrated and the parent-child couple is considered two people only linked because of logistical factors (such as the immaturity and dependency of the child on the caregiver), then there is little space for considering the full playout of the relational phenomena. In practice, while some art therapists performing dyadic therapy are also trained as family therapists, many others are not and yet have integrated a systemic view of the mother-child unit and developed dyad interventions stemming from other roots.

Attachment Theory and Object Relations

Both Attachment Theory and Object Relations tackle the broad phenomenon of human attachment, since humans are in constant attachment to other people, objects and places throughout life. Both models attempt to describe the dynamics of interpersonal relationships in which the relationship a person has had with the caregiver during infancy and childhood influences the interaction with the environment. Parashak (2008) writes: “the foundation of Object Relations and attachment is based on the first understanding and experience of the world that we develop in [mother-infant] partnership” (p. 65). It is then “the nature of the developing attachment and resulting Object Relations between mother and child [that] can predict the child’s future pattern of relationships” (Parashak, 2008, p. 66) and shapes the person’s interpersonal expectations for life⁷.

Attachment Theory. While there is overlap between the two models, Attachment Theory tends to focus on the actual relationship between infant and caretaker, on how and what

⁷ Concepts developed in this chapter focus on infant-caregiver. Throughout this paper there is a theoretical emphasis on the infant and toddler which is not necessarily coherent with the practice of dyadic art therapy. While theoretical grounding focusses on the early years of the mother-child relationship, the applications of dyadic art therapy are not restricted to this age group.

type of attachment is constructed. In James' (1994) words: "an attachment is a reciprocal, enduring, emotional, and physical affiliation between a child and a caregiver" (p.2) and the time between birth and age three remains the most critical for the reciprocal pattern of interaction to develop and be suitably reinforced (Parashak, 2008).

Psychiatrist John Bowlby broke from the psychoanalytic community of his time by proposing that the mother-infant relational phenomena was not so much the expression of unconscious fantasies but based in real-life events and human development. Bowlby was revolutionary in understanding attachment as a survival mechanism of the infant and young child and a healthy coping mechanism in adulthood⁸. In the beginning of Attachment Theory, the focus was on establishing categories of attachment based on observable behaviors of young children. From the *Strange Situation Procedure* designed in 1965, Ainsworth, Blehar, Water & Wall (1978) established three patterns of attachment behaviors that infants gradually develop from interactions with their caretakers and environment: *anxious-avoidant* (also called fearful), *secure*, and *anxious-resistant*, to which Main and Solomon (1986) later added *disorganised-disoriented*. The ideal secure attachment permits the child to consider the primary caretaker as a secure base from which he or she feels confident enough to go beyond the immediate protection and free enough to explore his or her world (Parashak, 2008). Mahler, Pine and Bergman (1975) outlined the stages in constructing attachment between mother and child which eventually lead to separation and individuation of the child (Malchiodi, 2012a).

The first attachment measurement was oriented towards applications with young children but research and clinical applications have expanded methods of evaluation of attachment patterns to other age groups. For the purpose of dyadic therapy, it is as relevant to be informed of the parent's pattern of attachment as it is to witness the child's. The caregiver's internal world, state of mind, and mental structure are the basis of the child's attachment pattern (O'Brien, 2008). Consequently, the caregiver's attachment pattern has a tendency to be transmitted to his or her children through transgenerations (Shah, Fonagy & Strathearn, 2010).

⁸ It should be noted here that Bowlby is considered to belong to the Object Relations theory school. Despite this, his theoretical understanding of attachment and *secure base* were key in stimulating the development of Attachment Theory.

Attachment Theory has evolved toward increasingly integrating the field of neurology and the development of tools and techniques that measure the brain⁹. Attachment patterns have been linked to different brain structures, and it has been convincingly demonstrated by research that the development of infants and toddlers is dependent on experiences embedded in attachment relationships. Felt insecurity with regards to the caregiver, as a consequence of on-going interaction and communication perceived as inconsistent, rejecting, neglectful or frightening, severely alters the biochemistry of the immature brain and leaves lasting physiological and functional traces (Schore, 2001b; Franklin, 2010). Wilkinson (2005) explains:

When trauma with its associated fight, flight and freeze responses has been experienced in the context of the earliest attachment relationship, then it becomes “burned into the developing limbic and autonomic systems of the early maturing right brain... [it becomes] part of implicit memory, and [leads to] enduring structural changes that produce inefficient stress-coping mechanisms (Schore, 2002, p.9)”. (p. 486)

While for the infant and child the bond with the primary caregiver serves psychological and biological needs, it also is the medium through which the child progressively learns to conceive his or her self negatively or positively and the exterior world as trustworthy or frightening (Franklin, 2010). Dyadic therapy is a natural outcome of Attachment Theory principles as attachment is key to the psychic well-being of the child and the future adult and “whether the bond is generally healthy or tainted, it remains the soil within which the child exists and through which the child can receive nourishment” (Shore, 2000, p.14-15).

Object Relations. Unlike Attachment Theory, Object Relations is not focused on the actual attachment relationship but how this initial relationship forges the psyche of the person, which in turn dictates the manner in which a person relates in the world. This school studies how the initial attachment with the primary caregiver is processed into an internal imprint which effect then “ripples out to other people and things” (Parashak, 2008, p.73).

In that Object Relations examines the perception, internalization and unconscious intrapsychic phenomena product of the initial attachment relationship, it is closer to psychoanalytic roots. Understanding the original notion of *object* is helpful to comprehend contemporary applications of Object theory. Freud originally posited that the object was a

⁹ Further explanation of the pertinence of neurological research to psychological intervention is beyond the scope of this project. However, I suggest consulting Schore (2001a, 2001b, 2001c) for a comprehensive

person (such as the mother), thing (such as the breast), or mental representation (such as the image of the mother or the breast) through which the person's libidinal energy is gratified.

Robbins (2001), an art therapist who works from an Object Relations perspective, explains:

Going back to its psychodynamic roots, the "object" in Object Relations theory refers to the who and what in which a person's libidinal energy is invested. By libidinal energy I mean that constitutional reservoir of energy and life that is part sexual, part aggressive, but is more than either. It is the fuel that motivates each of us to reach out and to find relief and contact from the world. (p.58)

The personification of this gratifying object was later perceived as being a role usually held by the mother: "Melanie Klein (1964) observed that it was someone (usually the mother) onto whom the child projects desires, wishes, or other powerful emotions" (Malchiodi, 2012b, p.70). Object Relations theory agrees to conceive the object as having originally been a real bond to the caretaker, instead of fantasy construct. However, the focus remains on how this object is constructed when internalized and in what way the object molds behavior and relationships. By adulthood, how a person has internalized bonds in relating to others deeply influences his or her style of thinking, remembering, and perceiving interior and exterior (Harris, 2004).

Linked to the concept of object (as belonging to subjective and objective reality) and important to art therapy is Winnicott's concepts of *transitional phenomena*. Winnicott is the first psychoanalyst to tackle the question about what lies between the inside and outside, or in the overlap of the intrapsychic and reality (Abram, 2007, p. 312). For Winnicott, there is "an intermediate area of experience where there is no clear distinction between inner and outer reality" (Malchiodi, 2012b, p.71), which he refers to as *transitional space*. In its capacity to bridge inner and outer realities, Winnicott's transitional space was also the locus of creativity and play in which both the internal and exterior are simultaneously engaged.

Transitional space is also where the infant gradually becomes aware of his or her separateness from the other and the environment. Winnicott also developed the concept of the *transitional object* which is an actual object (such as a blanket or toy) that is "a symbol of the journey the infant is making from the experience of... absolute dependence, to relative dependence" (Abram, 2007, p.313) from the mother. These transitional objects are imbued with

presentation of the complex results gathered from research in developmental brain activity.

meaning beyond the actual object. For art therapists, art making occurs within transitional space and art products can become transitional objects in that they can be receptacles of meaning beyond the actual creation itself.

In contemporary practice, Object Relations oriented therapy is helpful in tackling issues of separation and individuation, dependency and intimacy in light of the client's early attachment experiences. Additionally, for art therapists, Malchiodi (2012b) states that "Object Relations theory is a helpful construct in organizing art therapy and understanding the client's presenting problems... [where the] images created in therapy reflect past relationships, while the interactions between therapist and client support and enhance the process of individuation" (p.72).

Mother-child matrix theory

Most literature pertaining to dyads focusses on pairs of infants or very young children and their mothers, especially in the theory. I have mentioned previously other authors who also wrote about the mother-child unit (such as Bowlby, Mahler and Klein) but will here briefly review key concepts of Winnicott and Stern as they are recurrent theoretical grounding in the dyad art therapy literature (Appendix: Dyad art therapy readings).

Winnicott. Especially influential in Object Relations theory, this pediatrician and psychoanalyst is famous for stating that there is no such thing as a baby¹⁰. By this he meant that the infant as an individual only exists as an inseparable element of the "environment-individual set-up" (Abram, 2007, p.155), or, more simply put, in relation to the mother as primary caregiver. For Winnicott, the infant is "wired for harmonious interaction and non-traumatic development" (Mitchell & Black, 1995, p.114), but immaturity renders him or her completely dependent on the environment, which, if *good-enough*, will provide the necessary and adaptive conditions for the child's healthy and progressive development of self. Thus, this unit is not merely a mechanical feeding transaction but a dynamic duo composed of a mother who, from her state of *primary maternal preoccupation*, offers herself as a physical and emotional *holding environment*. The good-enough holding permits the state of *unintegration*, in which the child can feel secure and rely on "the mother's ego supportive functions" (Winnicott, 1965, p.61).

¹⁰ By Winnicott's (1960) own account, he first said these words circa 1940 in a discussion at a meeting of the British Psycho-Analytical Society.

The inner circle of the holding environment is the mother-infant dyad. Yet this relational unit is in need of constant support, and the mother in isolation cannot be a good-enough parent. Beyond the mother's personal abilities, the state of primary maternal preoccupation is difficult to engage in if not facilitated by the environment in which the father, family, and larger social support structure play key holding roles.

Stern. The psychiatrist and psychoanalytic theorist specialized in infant development is most known for developing the concept of overlapping and interdependent layers of early infant self which emerge through the relationship with the caregiver. Stern (1995) conceived the mother-infant dyad as the most essential type of dynamic in people's lives and that family and group interactions are mostly the sum of various dyadic relationships. Similar to Winnicott, Stern (1995) conceives the state of mothering, which he refers to as *motherhood constellation*, as a distinct realm of being. Stern (1995) writes:

I have come to realize that a mother is not just another patient, nor only a parent to a young patient, nor simply another member of a system. She is a woman in a unique period of her own life, playing a unique cultural role and fulfilling a unique and essential role in the survival of the species. It has become apparent to me that any treatment of the parent-infant relationship has to take into account the special nature of most mothers' predisposition to think, feel, and act in certain ways. (p.6)

Stern (1995) proposes a theoretical schema with which to understand the different realms of the dyad. The author considers the dyad as having two principal dimensions in their exclusive mode of relating. The first dimension refers to the realm of interaction consisting of "overt behaviors performed by each [individual] in response to and in concert with the other" (Stern, 1995, pp. 11-12). This interaction consists of observable actions which are visible and audible. The second dimension is located in the realm of intrapsychic phenomena and consists of the individual's unobservable subjective experience. This dimension, referred to as *representation*, consists of the remembered history of previous interactions and personal interpretations each member of the dyad has about the relationship. Representation could be compared to the individual's lens as it influences how an action will be perceived and interpreted. In Stern's (1995) words, "it is how [the mother] subjectively experiences and interprets the objectively available events of the interaction, including her own behavior as well as the baby's" (p.12).

Eclectic approaches to dyadic interventions

So far, I have presented an assortment of theories which are mostly derived from a psychodynamic perspective. The nature of dyad intervention also sets the scene for theory which investigates phenomena related to relationships. Cohen, Muir, Lojkasek, Parker, Barwick & Brown (1999) write: “Because most emotional and behavioral problems in infancy are seen as relational, there is general agreement that the focus of mental health intervention for infants must be on improving parent-infant relationships” (p.432). Furthermore, because the need to treat the infant through the caregiver and by means of this intimate relationship, not only do dyadic interventions focus on the relationship but operate by means of the relationship.

It might be helpful to theorize what different psychological approaches may resemble in a dyadic intervention. I return here to Stern’s (1995) model of the realms of dyadic interaction presented earlier. A behaviorist approach would naturally focus on the realm of action such as the motions executed by the caregiver in response to the child’s cues. A cognitive approach in turn would focus on the parent’s understanding and awareness of his or her action as a response to the child. Here we have entered the most superficial layer of the representational dimension of Stern’s model, with “the basic elements for a cognitive therapeutic approach or a limited psychodynamically inspired approach” (Stern, 1995, p.12). As for a psychodynamic approach, we enter into the core of the representations dimension where “the mother’s fantasy life [can] be seen to influence the infant’s fantasies, and vice versa” (Stern, 1995, p.14), and the playing out of transference and countertransference are included in the dyadic relationship and in the therapeutic scenario.

In practice, however, the differences between treatments may not be so clean cut. Stern (1995) argues that a division in approaches is artificial and that the nature of dyadic therapy and the infant-caregiver matrix intrinsically presents a multiplicity of *ports of entry*. The author offers the following explanation: if one concentrates on mother’s representation of her child (psychodynamic approach), this will inevitably be interrupted by the need for caregiving actions towards the child (pertaining to behavioral approach) and vice versa (Stern, 1995).

Again, we find ourselves with a tendency where dyadic interventions are somewhat undefined and present a combination of approaches (Stern, 1995; Cohen et al., 1999). Stern (1995) views this impurity as consequent to the novelty of treatment of mother-child units for which established therapeutic concepts have had to be adapted for use with this specific population. The mother-child population has evidently always been present, but it first began to

attract interest after the Second World War and increasingly in the last three decades. For Stern (1995), “at each major new encounter with an unexplored illness or never-before-treated clinical population, new treatment approaches emerge. And these invariably have implications for the existing approaches” (p.2).

Characteristics of dyadic therapy

The previous chapter presented the theoretical contexts in which dyad therapy is based. Stern (1995) writes: “theoretically and technically, the [dyadic] situation seems to be quite complex, even messy” (p.17). In comparison with therapies with other populations, the dyad is not a clean-cut structure and the practice of dyadic intervention calls for understanding the implications of these differences. I believe it is important here to bring forth some of the intrinsic characteristics of dyadic therapy, because these influences the manner in which it is conceived of and put into practice. I will first briefly present notions related to the structure of dyadic intervention, then develop the role of each actor within the dyadic intervention (the child, caregiver and therapist), then present thoughts in regards to the asymmetry between the members and discuss the child as an active agent in dyadic therapy.

Multimodality of intervention structure

Dyadic therapy lies in the grey zone between individual, family, and group therapy. Stern makes reference to certain fluidity where “the therapy is simultaneously an individual psychotherapy (with the primary caregiver), a couple’s therapy... and a family therapy... either at the same time or in sequence” (Stern, 1995, p.16). Moreover, defining the modality of a dyadic intervention may depend on the professional training of the therapist, the context of the intervention (clinical versus community based), and the specific features and needs of the individual dyad itself.

If we adopt a Winnicottian perspective, a mother-infant dyad is considered an undifferentiable unit where, in terms of relational phenomena, the child does not exist outside the mother and the mother’s reality is taken over by her mothering condition. Here, the parent-child relationship is considered as the client, and the focus of therapy could resemble more that of individual intervention, where the individual is not a person per se but the unit made up of their physical, communicational and representational interactions. Yet, even within the dyadic unit,

the de facto focus may not always be on the parent-child relationship, but may vary where the child or the parent, as individuals, take the spotlight for a certain period of time.

Structurally, the dyad is composed of two individual people, and, while not the stereotype of family, represent the most succinct and intense core of family. For Trad (1994), “because... the mother-infant dyad functions as a self-contained unit, the techniques of family therapy – including the resolution of enmeshment and triangulation – may be applied” (p.53). Yet in other contexts, such as a dyad with an older child, the caregiver-child may not be considered so much as a family but a group of two individuals (sometimes presenting very different needs and objectives), and thus the dyad intervention holds aspects of group therapy.

In the context of a group composed of various dyads, we must also add the potential interaction between two subgroups of peers, the caregivers and the children. Paul Trad (1994) perceives mother-infant group psychotherapy as a modality which by its very nature presents opportunity to integrate techniques of group, family, and individual therapy. When interactions happen at a family level (within the mother-infant unit), the therapist witnesses each member’s capacity to differentiate and assert individuality (Trad, 1994). During peer interactions (between mothers or between infants), what is being brought forth is “how individuals establish adaptive interpersonal connections” (Trad, 1994, p. 61) with one another. Finally, “the groups also provide opportunity for the therapist to gain access to intrapsychic functioning” (Trad, 1994, p. 71) of each member and thus call for the use of techniques of individual psychotherapy.

For Trad (1994), it is both the overlap of these three modalities (family, group, and individual therapy), as well as the transitions from one modality to another that contribute to the effectiveness of dyadic group interventions. The simultaneity of modalities offers a large spectrum of perspectives for understanding intrapsychic and interpersonal interactions. In turn, the transition from one modality to another offers insight into each individual’s adaptive abilities, and these shifts are helpful indicators of conflict.

Thus far, I have presented the notions of how dyadic intervention can present aspects of individual, family, and group therapy. It should, however, be noted that the actual structure of therapy may vary over time: a dyadic format of intervention can be used over a certain period of time, but the parent or child can potentially be seen individually, and more family members can be integrated into the dyad sessions. While the format and frame of the therapeutic intervention

may adapt to shifting needs, it is nevertheless possible for the therapist to maintain the primary focus on the dyadic relationship.

The main characters of the dyadic intervention.

A particularity of the infant-caregiver dyad is that “although it is the infants who are of greatest clinical concern, the actual focus of treatment is on the parents. This is most commonly performed either by directly altering parents’ behavior with the infant... or by altering their mental representation of their relationship with their infant” (Cohen et al., 1999, p.431).

Nonetheless, the parent also has individual needs and can be encountering difficulties within her or his parenting role. While it is the child-parent relationship that is being treated in the intervention, it is also important for the therapist to acknowledge and see each individual within the dyad. The particularity of having to attend the needs of the relationship as well as each member of the dyad influences the role of the therapist. Next, I discuss issues to consider about the child, caregiver, and therapist.

The child. Within the dyad, the child is usually of most clinical concern because of his or her vulnerability and dependency. In the case of infants and young children, there is an added urgency because of the speed of development: failures at this stage have implications throughout life and even reverberate to future generations (Hall, 2008, p.21). Fraiberg (1980) dramatically stated: “No baby can wait for the resolution of a parental neurosis which is impeding his own development” (p.53). In this section, I will focus mostly on the infant and young child client because it presents specific challenges. While aspects of the following discussion are relevant to older children, it can also be pertinent to any population in a situation of dependency and with limited voice in his or her environment.

As touched upon previously, both Winnicott and Stern highlight the difficulty in differentiating the young child from the parent: “how much of the infant’s psychological nature is a construct of the parent’s imagination (their wishes, fears, attributions, and so on) -- that is, of the [parent-child] relationship” (Stern, 1995, p.3). These blurry boundaries between infant and parent make it difficult to obtain information of the child as individual, and, from a Winnicottian perspective, this differentiation is irrelevant since the baby does not have individuality outside of the nurturing relationship with his or her caretaker.

The question of how to get to know this young person and obtain insight into his or her well-being is not always easy to put into practice. The child in his or herself does not generally

have any psychological condition: “diagnostically the infant is neither neurotic, borderline, nor psychotic. Is he normal? He has an infant psyche, whatever that may be” (Stern, 1995, p. 3), and psychological mental health classification systems are not relevant for young children.

Art therapist Lucille Proulx (2003) stresses the multidisciplinary aspect of working with infants and young children:

One cannot understand babies without some knowledge of development in the areas of motor function, language, and socialization. Nor can we begin our work unless we have an understanding of the temperament, including the self-regulation capacities of the infant in question. Finally, we have to be aware of the environmental influences on the baby, such as the health of the economy affecting the employment and financial situation of the family. In learning about all these factors, one crosses paths with many professionals who can add information and provide support. (p. 9)

Therapists most often integrate developmental frameworks in order to gain further understanding of the individual. Throughout life, but most dramatically during childhood, people follow expected, progressive, sequential and characteristic changes. Many normative developmental scales have been developed focusing on different aspects of human nature; a few examples are psychosexual, psychosocial, cognitive, motor development, phases of attachment, and Object Relations.

In addition to the developmental frameworks mentioned above, for art therapist, “it is important to have a solid understanding of the normal stages of artistic development not only in using a developmental approach, but also in using any approach to art therapy” (Malchiodi, 2012a, p. 116). In being able to recognize images, techniques and expressed content which deviate from the norm, the therapist is alerted to tune in to what this developmental situation or evolution could be indicative of for the client. The educator Victor Lowenfeld is probably the most influential in art therapy for his stages of pictorial development first published in 1947 (Lowenfeld & Brittain, 1947) and still used to this day.

Physical and developmental indicators in the child as well as behavioral, psychological and contextual factors in the primary caretaking environment are essential in evaluating the psychological well-being of the child. While continual maturation is an important aspect in all work with children, it is especially so with the population of early childhood when “the infant and his parents are in the throes of the greatest and fastest human change process known: normal

early development” (Stern, 1995, p.3). While this evolution can be exhilarating, these changes can also be deeply confusing and destabilizing. Case and Dalley (2008) write: “developmental progress does not necessarily take place smoothly, but often through leaps in physical, emotional and cognitive achievements... It is helpful to consider that progress represents a gain for the child, but also loss of the previous stage, and it is not unusual for the child to regress at times of anxiety and uncertainty” (p.1).

Here, from a developmental perspective, the caregiver “helps the infant not only master the new skills, but also to overcome the uncertainty that arises when new capacities are emerging” (Trad, 1994, p. 74). Trad (1994) refers to the paradox inherent to the process of maturation: “Mothers and infants grow closer together (in terms of emotional sharing) in order to grow further apart (in terms of the infant’s manifestation of autonomy)” (p. 74). This phenomenon may be the base of conflict for the parent with issues of separation, which in turn may harbor implications in the child’s process of working towards individuation.

Natural maturation of early childhood can also affect the therapeutic work and presents another particular aspect to consider when working with young children: the “unavoidable confusion between therapeutic change and developmental change” (Stern, 1995, p.7). It could be argued that it is pointless to differentiate psychological from motor or cognitive development in young children as these aspects of development are intertwined. By their intrinsic nature, developmental milestones are multifaceted. Crawling, for example, requires the infant to simultaneously develop motor skills (such as specific muscles and coordination), cognitive abilities (inventing and perfecting certain gestures through trial and error because the action of crawling itself is not demonstrated by the caregivers), and emotional maturation to be able initiate and survive physical separation from the caretaker.

While knowledge in child development and close attention to milestones as indicators of well-being are certainly essential for professionals working with children, art therapist Annette Shore (2000) offers a different perspective on the subject: “A child therapist rides the wave of a child’s development in hopes of fostering genuine strength so that the child can experience more substantial maturation” (p.14). Here, healthy and well-rounded maturation is the objective of the therapeutic intervention: the child will develop one way or another, but the opportunity that dyadic therapy offers is to optimize this natural process by “accessing and using parents’ strengths to serve the child’s development” (Shore, 2000, p.14).

The primary caregiver. Here again with the caregiver¹¹ there is a theoretical emphasis on the period of caring for an infant or young child. While the first three years of child rearing are usually the most intense for the caregiver and important to the survival and well-being of the young person, there is need for more understanding about the mothering role throughout human life.

For Winnicott and Stern, the perception of the mothering state was created with the infant and young child in mind. The person caring for the infant may have a psychological diagnosis, but most of all, this person has a specific psychological condition which entails caring for a young child. In Winnicott's view, "the mother is not in her right mind. The state of maternal preoccupation is a constructive kind of madness that enables the mother to suspend her own subjectivity to become the medium for the development of the subjectivity of the infant" (Mitchell & Black, 1995, p.126). This state of being is both natural and essential to the caring for an infant.

For both Winnicott and Stern, this state of being renders the mother of a infant or young child an inauspicious client for regular individual treatment: "psychic organization makes the mother a patient who cannot be properly seen when viewed through the lens of a therapy designed for other sorts of patients" (Stern, 1995, p.3) because the mothering condition is expected to intrude onto other aspects of life. It is however expected that with maturation of the child, the place occupied by the mothering role diminishes as the physical and emotional needs of the infant gradually wane.

It is well documented in recent literature that the mother's well-being can have direct influence on her child. Literature seems to focus on situations of mental illness (mainly psychosis and depression), abuse and trauma in childhood and/or in adulthood, and social contexts of extreme insecurity (such as homelessness, poverty, and war). Among others, Hipwell, Goossens, Melhuish and Kumar (2000) studied the effect of severe psychopathology in the mother on infant-parent attachment, and Hobson, Patrick, Crandell, García-Pérez and Lee (2005) explored attachment in infants with mothers with borderline personality disorder. Apter-

¹¹ The literature most often refers to a single primary caregiver, especially in the case of infants and young children. Yet a single caregiver may not correspond to the reality of many infants and children and even be uncommon practice in certain cultures. The general consensus is that infants form more than one attachment, each leading to an independent working model, and are organized in a hierarchy of preference (Noppe, 2000). Dyadic interventions developed by Cohen et al. (1999) and by Ben-Aaron, et al. (2000) equally integrate both parents.

Levy, Feldman, Vakart, Ebstein and Feldman (2013), Flykt, Kanninen, Sinkkonen & Punamäki (2010) have studied maternal depression in relation to attachment and infants' behaviour.

Fraiberg, Adelson and Shapiro (1975) marked the field of parent-child psychodynamic intervention with the seminal article "Ghosts in the nursery". The authors suggest that the treatment of the dyad must include treatment of the mother's childhood traumas in order to counteract the recurrence of inter-generational relational dysfunctions. When attachment trauma has occurred, the consequences "are powerful and enduring wounds that can profoundly influence the course of the [mother-child] relationship" (Whiffen, 2003, p.390). Parashak (2008) explains that a mother's behavior can be marked by relational injuries and "may be a result of unconscious reaction to past events, particularly when the child reaches the age of early trauma of the parents. In art therapy, using art materials appropriate to an early developmental stage (such as the act of finger painting) also has the potential to trigger the surfacing of unresolved issues from the parent's childhood.

Yet adults from difficult childhoods are not doomed to reproduce the intergenerational scheme: Parashak (2008) writes: "mothers from troubled backgrounds can be good mothers, but conscious efforts towards new sensitive approaches to their child may be in order" (p. 71). Dixon, Browne and Hamilton-Giachritsis (2009) explore factors that promote or protect against intergenerational reproduction of infant maltreatment. These vulnerable caregivers may need extra help from their support system to compensate for the shortcomings of their past, and therapy "becomes a supportive holding environment in which the infant mental health worker cares for the mother and helps her to process the ways in which her needs were not met as a child" (Malone, Levendosky, Dayton & Bogat, 2010, p.448).

The mother's attachment model and experience of childhood are factors which influence a mother's ability to become a good-enough environment for her child and permit a positive and secure bond. By adulthood, how a person has internalized bonds in relating to others also deeply influences his or her style of thinking, remembering, and perceiving interior and exterior (Harris, 2004). Past difficulties can be especially activated by stress and significant life events such as the transition to parenthood (Flykt et al., 2010). Flykt et al. (2010) have found that the parent's attachment structure influences parental abilities and that "dyads with secure autonomous mothers tend to show higher quality of interaction, including higher sensitivity, affectivity, structure, synchronicity and child responsiveness" (p.532). The mother's attachment model is

generally perceived as a protecting agent that can compensate for other inauspicious factors such as mental health issues or harsh environmental conditions. For example, mothers with secure attachment manage to relieve the effect of their depression on their child, while insecurely attached mothers' depression seems to exacerbate the negative effects on the child (Flykt et al., 2010).

Finally, the environment in which the mother is cared for and receives support is key to her being able to provide a good-enough mothering environment. Severe and on-going harsh and inauspicious social contexts in the present are often concomitant with other factors. For example, homelessness, which includes other risk factors such as poverty, mental illness, and social isolation, impacts a mother's parenting abilities and chronic residential instability "is associated with children's mental health problems, particularly internalizing disorders (e.g., anxiety, depression, social withdrawal, and somatic symptoms)" (David, Gelberg & Suchman, 2012, p.2).

The therapist. There is extensive literature available about the role of the therapist, but the traditional psychodynamic view of the therapist's role may not apply to the dyadic modality. Taylor Buck et al. (2013) state that adopting a systemic perspective in dyadic art psychotherapy:

Challenges the more traditional emphasis on the relationship between therapist and client. The focus shifts from the therapeutic relationships with the therapist and image... to intra-familial relationships. Similarly within the field of attachment-based interventions the focus is the parent-child dyad rather than the therapist-client relationship. (p.20)

In this section, I will discuss issues of the therapist's role and transference in relevance to the dyadic format.

The therapist's role. As seen previously, for Winnicott the infant as an individual only exists in relation to its environment. Beyond the mother's personal abilities, good parenting seems improbable to practice if it is not facilitated by the environment in which the father, family, and larger social support structure play key holding roles. As one of the possible members of this environment, the therapist has the opportunity to offer needed support so that the dyad can overcome challenges and develop to its best potential.

In dyadic therapy, because the focus is the relationship between the two people, therefore it is expected that the intervention should be oriented towards working on this observed interaction in the here and now. Rather than focusing on one member of the dyad, the therapist

must strive to balance the needs of both the caregiver and the child in order to promote the building of their relationship (Parashak, 2008). From a family art therapy approach, the goal is “working towards changing the system by being a caring witness to their process” (Sutherland, 2008, p.170). The therapist thus “work[s] with the system, not the individual” (Hoshino, 2008b, p.138) in hope of assisting the family’s co-creation of a new reality.

The goal is to improve the quality of interaction and communication between the mother figure and the child, which for children is usually accomplished through practice of one form or another of play. With this practice of attunement within the safety of the therapy session, the intention is that the caregiver gradually gain confidence in his or her mothering abilities and be progressively more comfortable and successful in this role. The interactions occurring in the session may then become rewarding experiences, and these events will hopefully reinforce the engagement within the dyad both in session and in day-to-day life.

In family therapy, there is emphasis on the notion of joining into the family system in order to be able to understand the family’s mode of interaction and assist in making positive changes. As referred to by family therapists, the “job is one of joining with the family without being absorbed into it” (Sutherland, 2008, p.170). While working with a dyad may involve proximity of the therapist with the client system, this does not mean participating in destructive interactional patterns such as coalitions or triangulations. Setting boundaries thus becomes a constant necessity. Hoshino (2008b) recalls that James Framo (her former professor) summarized that “his role as a family therapist was to set the boundaries of therapy” (p.138).

Parashak (2008) makes the analogy that the role of the therapist in attending a dyad “is much like the mother who watches carefully as her child explores, ready to provide nurturing or guidance if necessary, but allows the child to search independently, to learn about things on his or her own” (p.79). Indeed, many authors refer to the role of the therapist within the dyad therapy environment as being maternal holding.

Transference. We can make sense of transference in a variety of ways. From a Winnicottian perspective, the therapist can be seen as playing the role of the *symbolic father* who creates and ensures a good-enough nursing environment in which the caregiver is supported and empowered in order to synchronize her or himself to the needs of the child. Stemming from Winnicott’s concept of good-enough mother and environment, Stern (1995) developed the concept of *good grandmother* transference. This term was developed in the context of mother-

infant interventions where Stern (1995) posits that mothers have an innate need “to be valued, supported, aided, taught, and appreciated by a maternal figure” (p.186). For Regev & Snir (2015), the good grandmother function “defines the position of the therapist in relation to the dyad” (p.54) but particularly in relation to the parent. In their research, they found that art therapists using parent-child art psychotherapy “felt this involved providing the parent with support from an empathetic, supportive and non-judgemental standpoint.... [where] the therapist tries to get her position and viewpoint across in a way that does not detract from, compete with or threaten the parent’s status” (Regev & Snir, 2015, p.54).

The therapist can also become the *good-enough mother* in what Chethik (1989) refers to as *transference parenting*. Shore (2000) explains this particular therapeutic relationship as that in which “the therapist functions symbolically as the nurturing parent to the child’s parent... providing a sense of safety, security, and stability for both parent and child” (p.18). In this perspective, the focus is more on the need for mothering of the caregiver. If a mother as a child had never truly been seen, mirrored, and cared for in a safe environment, it would be difficult for her to adopt this conduct with her child. From this perspective, it is often first necessary for the caregiver to experience receiving ego-support and fulfil some of the unmet needs of his or her own childhood, in order to be able to reciprocate this model and address the child’s similar needs. The experience of being seen and listened to by the therapist in session can permit the caregiver to genuinely reciprocate this experience with the child.

Mothering the mother within the dyad intervention is also inviting the emergence of relational material from the caregiver’s childhood experience. Hoshino (2008b) writes:

There is some truth in the statement that when you treat a family, it at times feels like you are treating several generations of ghosts. These ghosts inform, influence, and may, at times, seem as alive as (or perhaps even more alive than) the living, breathing family that sits in front of you in the therapy room. (p.133)

Several authors find that transference and counter-transference take a particular form in dyadic intervention. Therapy seems to be unavoidably swept into a powerful transference and counter-transference phenomenon intrinsic to working with the intensity and depth of the relationship of this clientele (Shore, 2000). Art therapist Lucille Proulx (2003) offers an interesting perspective concerning the challenges of working within the realm of the dyad’s relational phenomena: the communication is principally non-verbal (especially in the case of

infants and younger children) and requires that the therapist must be attuned to subtle ephemeral clues and able to respond, intervene, and interpret in this same fleeting language. Proulx (2003) suggests that it is the nature of these non-verbal and intra-psychic communications that, being fundamentally primitive for all of the people involved (child, parent, and therapist), render all phases of therapy particularly emotionally draining and difficult to make sense of.

While what I have presented here is an assemblage of perspectives of the role of and goals of the therapist working with dyads, I believe Hoshino's (2008b) words bring some grounding to this diversity:

Much more than the techniques, prescriptions, or interpretations, it is the therapist's behavior that helps families change... While performing these various roles, the therapist maintains such qualities as a respectful curiosity, a commitment to help families change, a preference for concrete behavioral modifications over talk about changed feelings, a constant readiness to formulate and modify hypotheses based on information received, and the ability to imbue the sessions with an intensity while keeping the clarity of the therapeutic goal" (p.128).

The child's voice in dyadic therapy

When considering the individuals involved in dyadic therapy (the child, parent, and therapist), we must recognize that not everyone is on equal ground. The therapist, because of his or her professional role, is in a situation of power, whereas the client role is by definition one of vulnerability where normally hidden aspects of life and psyche relationships are exposed. Also the therapist's relating to the caregiver is arguably easier and the predominantly verbal nature of adult communication favors the therapist-parent interchange.

The relationship within the parent-child dyad is also realistically asymmetrical, where the adult generally holds the position of control and power whereas the child is vulnerable and dependent on the parent. This imbalance is expected and necessary as the child needs to be able to gradually build his or her self while using the caregiver's ego strengths. In general, the younger the age of the child, the less power he or she will have within the dyad; however many other factors such as personality, personal history, health, etc. can come into play and alter the power relation.

An important aspect of power is the possibility and ability to advocate for oneself, which is to communicate one's desire and have space for the expression of self. Yet this self of the

child is in construction. Stern (1995) writes: “this [parent-child] relationship is influenced by a rich and full past history on the parents’ part and a quickly accumulating but still minimal one on the infant’s part” (p.3). Here the parent holds a position of influence in which his or her inner world and mode of interacting with the environment over-shadow the one of the child. As developed previously, access to the young child’s nonverbal and mostly pre-symbolic language is difficult most often mediated by the caretaker.

While the inherent asymmetry in the dyadic relationship is an important element to acknowledge in dyad intervention, this does not mean that children or even infants do not have the ability and desire to be active participants. Since the development of Attachment Theory and the understanding of the newborn as being “predisposed to relate and be sociable in ways that further its healthy development” (Hall, 2008, p.28), it has been convincingly argued that the baby is not a passive being: “from the start these [innate human] motives are intersubjective, [and babies] attract and engage with other persons” (Trevarthen, 2001, p.97). In fact the infant not only responds to stimuli but “very young babies were seen to be seeking active engagement, instigating exchanges themselves and not merely responding to their carer’s signals” (Hall, 2008, p.25).

The studies reviewed for this paper suggest a variety of ways to perform dyad therapy and different factors which influence the best configuration for each client. The child’s active involvement is an aspect which varies greatly in dyadic interventions, but the tendency is to increasingly consider the child as an active agent. Cohen et al. (1999) invite dyad therapists to not merely treat the infant through the parent but give the infant a leading role in the process of therapy, as the authors’ research found this approach to have a positive effect on the outcome. In reference to their parent-child psychotherapy method, Harel, Kaplan, Avimeir-Patt & Ben Aaron (2006) write: “In the dyadic sessions, we observe the children trying to teach the parents how they need them at this specific phase of development. Children are active in co-constructing with the... parent new relational patterns and reorganizations of meanings” (p.29).

In art therapy, the focus on the child’s active involvement is perhaps best illustrated in the work of Lucille Proulx (2003) in which, despite a directive format, the session are led by the child. In her interventions, the caregiver is invited to follow the child’s lead; adjust his or her actions (in art making and play) to the child’s level and overall interactive language within the session is adjusted to be accessible to all members.

On the other hand, since it is the caregiver who has the most influence on the well-being of the child, it is also arguably efficient to focus on the needs of the parent. What is needed in treating the dyad is not merely to retrain the parent but to have empathy and foster the parents' strengths. Shore (2000) writes: "it is more often helpful to support very needy parents in their own parental struggles while sincerely recognizing their strengths" (p.16).

To illustrate this end of the parent-child involvement spectrum, Ponteri's (2001) research investigating the effect of group art therapy with depressed mothers and their infants is a good example. While the intervention aimed to improve mother-child interactions, the therapist's attentions focused on the depressed mother's needs. Mothers work at a table while children are looked after by childcare workers in another part of the room. Here the intervention does not actively include the children in the art making or therapeutic group work, yet because the intervention focusses on the mother's perception of her child, it is in fact directly tackling an essential aspect of dyadic phenomena. Integrating Stern's (1995) theory discussed earlier, the art therapy focusses on the mother's perception of her relationship with her child which in turn has direct influence on her actions, the child's behavior and the child's representation.

The development of dyadic art therapy

In 1974, art therapist Judith Rubin wrote that "working with mother and child together in art is certainly not new, and... instances reported in the literature may represent but the tip of the iceberg" (p.166). The scarcity of art therapy literature centering on dyadic intervention has been the norm until relatively recently when there has been a substantial and worldwide increase in published material by art therapists.

This present section aims to discuss how dyadic art therapy developed into a modality of its own right: I will concentrate on the authors and time periods that led to this development within the field of art therapy. I will first review the origins and historical context in North America that permitted the development of art therapy and highlight instances of dyadic format within this period. My description of the first phase of development of dyadic art therapy is mostly based on written traces found in art therapy literature. The second phase corresponds to varied affirmations of dyadic art therapy as a modality in its own right, leading to the present consolidation and expansion of dyadic art therapy in intervention, research and an acknowledged presence in creative arts therapy literature.

The prehistory of dyadic art therapy

To understand the roots of dyadic art therapy, it is necessary to briefly review the development of art therapy and of family therapy in the United States that would eventually lead to art therapy interventions with dyads¹². I will then reveal and discuss the use of the dyadic format as it appears in the early literature by pioneering art therapists who worked with children. Keeping in mind that there was no formal education until 1969, art therapy “took root and grew in several places simultaneously” (Hoshino, 2008a, p.39).

Art therapy is generally considered as a “hybrid discipline based primarily on the fields of art and psychology” (Vick, 2011, p.5). Both in Europe and in North America, the emergence of art therapy was greatly influenced by psychodynamic thinking of the nineteenth and twentieth centuries (Malchiodi, 2012a, 2012b; Vick, 2011). However, in the case of art therapy with children, it is perhaps equally relevant to consider how early psychoanalytic theory and practice influenced the field of education and brought new understandings to child development. Vick (2011) writes:

The significance psychoanalytic writers placed on early childhood experiences made the crossover of these [psychoanalytic] theories into education an easy one (Junge & Asawa, 1994). Some progressive educators placed particular emphasis on the role art played in the overall development of children (Cane, 1951, 1983; Kellogg, 1969; Lowenfeld, 1987; Uhlin, 1972, 1984). This trend toward the therapeutic application of art within educational settings continues today (Anderson, 1978/1992; Bush, 1997; Henley, 1992). (p.7)

What follows is a description of various niches of early art therapy from which dyadic format may have grown. It should be noted here that I do not aim to determine a specific origin of dyadic art therapy but offer a perspective on possible options from which to gain context for the gradual development of this modality.

Parent-child format in art education. While there is still an overlap between the field of art education and art therapy, this was more notable in the early years of art therapy while it was being defined as a profession. Moreover, many pioneer art therapists (such as Margaret

¹² For more information regarding the equivalent development in Great Britain, I suggest consulting Waller (2013) and Hogan (2001).

Naumberg and Hanna Kwiatkowska) were formally trained as educators before there was official training available for art therapy. Waller (2006) writes:

Many of the founder art therapists were art teachers and were influenced by their own art education which in the late 1930s to 1950s tended towards the ‘child-centered’ approach... [which] continued in a modified form well into the 1960s under the influence of Herbert Read (1943) and Viktor Lowenfeld (1947). (p.275)

Based on Rubin’s (1974b) account, non-clinical practice parent education where parents and children made art together appeared to be common practice. While this cannot be verified without more in depth exploration, it would not be surprising if the American mothers of art therapy had attended mother-child pairs: those such as Cane, Naumberg, Kramer, and Kwiatkowska worked extensively with children. Rubin mentions instances taking place in museums, schools, nurseries, etc., and Rubin herself lead several community interventions, which will be presented in a later section¹³. Particularly influential is the work of D’Amico in the Museum of Modern Arts of New York who writes: “The aim of these classes is to give parents the shared experience of observing their children create under the guidance of a skilled art teacher... working alongside the child...watching him grow and growing with him” (D’Amico, 1960, as cited in Rubin, 1974b, p.219).

These instances, while educational in focus, emphasize the need to respect the child’s mode of expression, understand the child’s world, and the inherent pleasure in art making which can promote better understanding between parents and children (Rubin, 1974b). This is indicative of the belief in the inherently therapeutic nature of art making which is expressed in both art therapy and art education. To illustrate this perspective, Malchiodi (2012a) writes: “Lowenfeld (1957) believed that the art process contributed to many aspects of children’s creative and mental growth ... [and] that art making not only was a source of self-expression but also had the potential to enhance emotional well-being” (p.115). This posture is similar to what art therapist Kramer (greatly influenced by Freud) named *Art as therapy*, where the process of art making is seen as potentially therapeutic because it involves sublimation as a positive conversion of impulses (Vick, 2011).

¹³ Despite the fact that Rubin (1974b) presents these community dyadic instances as educational in focus, I feel that they are best discussed as dyadic interventions of art therapy.

Dyadic format in family art therapy. I have not found early literature describing dyadic interventions by authors who consider themselves family art therapists. Family therapy, as developed previously, is influential to dyadic art therapy where the dyad is undeniably the most succinct possible configuration. I believe that it is safe to assume that family art therapists attended dyads, as they still do today, and for this reason it is worth briefly presenting the work of pioneer family art therapists.

Of those art therapists who worked with children, many found support in the burgeoning field of family therapy. It is impossible to mention family art therapy without referring to Hanna Kwiatkowska. Kwiatkowska, who was trained as a visual artist and educator in Europe and deeply influenced by psychoanalysis, is commonly considered as the first family art therapist (Wadeson, 1980; Junge & Asawa, 1994; Hoshino, 2008a). She published extensively in psychiatric, family therapy and art therapy journals. Notably, she wrote the first book on family art therapy in 1978. Wadeson (1980) writes about Kwiatkowska's legacy: "from her pioneering work in the 1960's, others have branched out to adapt her methods and develop new ones for using art therapy with many kinds of families in various treatment settings" (p.280). Vick (2011) also highlights the importance of Kwiatkowska in bridging art therapy and family therapy, reminding that a number of influential art therapists (making mention of Landgarten, Linesch, Riley, Malchiodi, and Sobol) have built on Kwiatkowska's work with families, "particularly in California where art therapists become licensed as marriage and family therapists" (p.12).

As a family art therapist, Kwiatkowska is known for defining and marking the ground of both novel disciplines of family therapy and art therapy. Her publications focussed mainly on art-based interventions for families (both as adjunctive techniques and as primary mode of intervention) (Kwiatkowska, 1962, 1978), and her research concentrated principally on developing art-based evaluation techniques for use in family assessments for family practitioners. Kwiatkowska's focus was on inserting art as a valid therapeutic method in family therapy. Perhaps, Kwiatkowska's greatest contribution to art therapy was being able to ride the wave of family therapy development and creating a space for art therapists in working with families.

Dyadic instances in art-based family assessment. Vick (2011) writes: "one of the strongest trends to emerge within modern psychology has been the focus on standardized methods of diagnostic assessments and research" (p.7). American art therapists of the second

half of the 20th century were no exception to this trend and “nearly all the major art therapy writers [such as Kramer; Kwiatkowska; Rubin; Ulman] from this time developed their own methods of assessment consisting of batteries of art tasks” (Vick, 2011, p.8). Considering the incorporation of the notion of sublimation as a fundamental concept in art therapy (the art work is perceived as uncovering something of the artist’s psyche), most assessments developed by art therapists were projective in nature.

While the time and energy dedicated to creating these diagnostic tools may seem disproportionate from today’s perspective, it is important to consider the historical context where art therapists needed to validate the field. Hoshino (2008a) explains that the founders of family art therapy focused “mainly on developing assessments and developing clinical proficiency so families were efficiently helped through art therapy” (p. 39). The development of methods of assessment, built from research and clinical experience, served to establish efficacy and gain recognition for the field of art therapy (Hoshino, 2008a).

Several art therapists developed family assessments¹⁴ where dyadic format is used, either by requiring making of art in pairs within large families or by using the assessment with the dyad as family. The most influential of these is Kwiatkowska’s (1978) *Family Art Evaluation*, which served as a reference for future generations of family art therapists (Rubin, 2001). During the same period that Kwiatkowska developed her art-based assessment, Zierer, Sternberg, Finn and Farmer (1966a, 1966b) developed the *Creative analysis* for individuals or families. This assessment uses a combination of structures within large families and makes specific mention of dyad art activities in the presence of family members (Zierer et al., 1966a, 1966b).

The purpose of these family assessments was to access information regarding family issues and dynamics in order to inform subsequent interventions in individual or family art therapy. However, the use of dyadic structure in assessment with diagnostic intention may have opened possibilities to use dyadic structure in therapy. When the art therapist witnessed how “art-based assessments provide the family with an opportunity to creatively explore and collaborate through process of making art together” (Kerr, 2008, p.157), it is easy to imagine how these benefits could have been an incentive to reproduce this format in treatment.

¹⁴ For an overview of family art assessments, I suggest reading Hoshino (2008a) in which she dedicates a section to family art assessments.

Dyadic format in art therapy interventions.

The first wave of dyadic format in art therapy, as described by published material, occurred during the 1970s. Here caregiver-child interventions are not presented as a specific modality but as a possible format within group, family or individual art therapy. I will first describe the use of dyadic structure as secondary to another configuration, and then describe the instances where dyadic art therapy is used as the primary format of treatment.

Dyadic sessions as adjunctive. The literature review revealed two authors who wrote about dyadic sessions as adjunctive to another form of treatment of art therapy. The dyad structure is a secondary configuration of interventions where dyad sessions are not the habitual format of therapy, but rather exceptional.

In 1974, Rubin published two articles focusing on interventions which use dyadic structured sessions. The cases presented in these two articles are incorporated in to her doctoral dissertation (1976) and *Child Art Therapy* editions (1978, 1984, 2005) in similar form¹⁵. Focused on a clinical setting, the first article (1974a) describes two case examples of mother-child pair art sessions. The first case is a year-long individual intervention where mother and child were mostly seen separately. The second is a multimodal group family intervention where children participated in an art therapy group while their mothers attended mostly verbal group therapy. Within the regular format of both of these interventions, there were a few dyadic art therapy sessions where participants were invited to work in mother-child pairs. In both cases, the initial motivation for having a dyadic session was because it presented “many opportunities for observation of dyadic interaction patterns.... [and is] particularly helpful in management and planning of the treatment” (Rubin, 1974a, p.170-171).

Rubin’s (1974b) second article focused on various dyadic art therapy interventions as one-time events within other community programs (a summer art program for visually impaired children, an elementary school, and a church’s mothers’ group). In all settings, large group mother-child non-directive art workshops were organized. In all family art workshops, mothers and children were encouraged to make art together, and these events were followed by a mothers-only discussion group. Rubin reports that both mothers and children perceived these experiences as rewarding, instructive, and helpful in learning about the other. Rubin (1974b)

¹⁵ The latest edition of *Child art therapy* (2005) incorporates more varied material and a somewhat different stance about dyadic art therapy, which will be discussed further on.

concludes that “shared art experience for mother and child... [is] a useful tool for parent education” (p.227).

In an attentive reading of these two articles, Rubin (1964a, 1964b) points to benefits of these dyadic interventions that surpassed the initial goals (diagnostic in the clinical setting and educational in the community setting). In the clinical setting, Rubin (1974a) describes the dyadic experiences as highly effective interventions: for the individually treated mother and child, she describes the dyadic session as pivotal within the course of treatment; and the dyadic group experience permitted the mothers to integrate more positive change. Rubin (1974a) also writes that “less apparent but perhaps more important for the participants is the educational potential of such sessions” (p.175) where these sessions are not only informing the therapists but also directly beneficial experiences for the clients. Finally, Rubin describes these dyadic experiences as having been highly pleasurable: “great pleasure may be gained from [dyadic] creative art experience” (1974b, p.227), and children especially “liked it better with the mommies” (1974a, p.180).

Following these first two articles, Rubin included cases of dyadic work in many of her later books pertaining to art therapy with children (1976, 1978, 1984, 2005). Rubin increasingly leaned towards directly considering “that the use of joint mother-child group art sessions at intermittent intervals seems to provide useful diagnostic and therapeutic opportunities for all involved... [and] may indeed help [mother and child] to develop a new mode of communication” (Proulx, 2003, p.25).

Lachman, Stuntz and Jones (1975) wrote about the experience of two dyadic sessions within the treatment of a mother and her son seen individually in psychotherapy. The goals were to obtain further assessment of the mother-child relationship and deal directly with issues of transference and counter-transference involving the clients and the two therapists. An external art therapist was brought in for the two dyadic sessions in which the two individual therapists were present. While the authors describe the mother-child relationship as unhealthy, the discussion in the article focused little on the dyad’s relational phenomena and mostly centered on transference issues stemming from fantasies of each client towards the other therapist. Despite this, Lachman et al. (1975) conclude that “occasional joint art therapy sessions to supplement individual counselling can be an effective way to further the therapeutic progress of mother and

child” (p.116) and viewed this dyadic experience as efficient in making overt issues that had previously only been suggested.

Rubin (1974a, 1974b) and Lachman et al. (1975) write about art therapy sessions with parent-child pairs as exceptions within the regular frame where parents and child are attended separately. These articles present situations which are not truly dyadic therapy in that the caregiver-child relationship was not necessarily the focus of the intervention: they are adjunctive therapeutic instances to inform the normal mode of intervention. Nonetheless, these articles, which highlight the benefits of the dyad sessions and pose important questions, can be seen as a movement towards considering the dyad as a valid therapy configuration on its own.

Dyadic sessions as main mode of intervention. The earliest mention I have found of the use of art with a therapeutic objective within a dyad is Naumberg’s (1965) case example, which is best described as dyadic filial art therapy. Within the context of coursework and supervision, a student of Naumberg conducted filial therapy concentrating on the mother-child relationship through the use of art making. Because the mother and therapist in this case is the same person, I do not consider this intervention as belonging to dyad art therapy. However, this example is insightful in its understanding of artwork as a method facilitating and strengthening the mother-child relationship.¹⁶

To my knowledge, Landgarten is the first art therapist to publish regarding an intervention that adopts dyad structure as the main show. In her article, Landgarten (1975) describes a group of four mother-daughter pairs who met for eight art therapy sessions with the goal of working on mother-daughter communications¹⁷. The author highlights how art making balanced communicational abilities between mother and child and how dyad groups provided an opportunity for multifaceted exploration of interpersonal relations. Landgarten (1975) writes: the “mother-daughter art therapy group offered its participants an opportunity to experience and explore themselves variously: as individuals, in pairs, with others of their own generation, and as members of an all-female group” (p.35). Nearly two decades later, Trad (1994) developed this same notion: dyad art therapy groups present the opportunity for participants to simultaneous take advantage of the benefits of individual, family and group therapy (see previous chapter).

¹⁶ For more information regarding this specific modality, I suggest reading “Filial art therapy: A Rogerian approach” by McCarly (2008). Also, art therapist Jean Davis (2003) offers a personal account of her experience of art making with her infant child.

Landgarten developed her work “at the Thalian Outpatient Clinic... [which] was a major resource for family therapy while the field was developing” (Hoshino, 2008a, p.48). She presents the group dyad intervention as group therapy. While she does not consider work with dyads as a specific modality, Landgarten (1975), however, acknowledges the different nature of the presented case in that the focus of the sessions was on the mother-daughter pairs and on offering opportunities for them to improve their communication, work through dysfunctional relational patterns, and experience meaningful and successful interactions.

A lull in development between waves of development.

After a first wave of publishing in the 1970s and before the next at the turn of the century, interest in dyadic art therapy interventions seemed to become dormant. Despite this, there are indications of some art therapists independently developing dyadic therapy interventions. Here, I will review the published literature and present art therapists who were integrating dyadic methods into their art therapy practice during this period.

After the Rubin (1974a, 1974b), Lachman et al. (1975) and Landgarten (1975) articles focusing on dyadic therapeutic work and Landgarten’s (1975) presenting of dyadic art therapy as principal mode of intervention, one would have expected the intensity of development to continue. However, in the two decades that followed, the only art therapy literature concerning the dyadic format of intervention I have found is written by Judith Rubin (1976, 1978, 1984), adding little new information.

In 1976, Rubin submitted her doctoral dissertation *Children, Art, and Growing – in Diagnosis, Therapy and Education*, which included a section about individual and group dyad therapy. The dissertation was the foundation for Rubin’s classic reference book *Child Art Therapy* first published in 1978, followed by a second edition in 1984, and a third in 2005. From the first edition to the second, there are little changes in case examples or material added relevant to dyadic intervention¹⁸.

In the first and second editions, Rubin (1978, 1984) includes two relevant chapters focusing on clinical settings, one which concentrates on group interventions and the second on individual work. The case example for group intervention is the same as in the 1974a article

¹⁷ The intervention also involved two individual pair verbal interviews and two individual short sessions with each separate member of the group (Landgarten, 1975).

presented earlier, with dyadic group sessions used at intervals with separate therapy groups for mothers and children. As for examples of dyadic structure used with individual clients, Rubin gives four case studies (of which one is the same as in the 1974a article) where dyadic sessions are used occasionally when parent and child are attended in separate individual treatments.

As in her previously published articles regarding clinical instances, Rubin (1978, 1984) uses the dyadic structure as a secondary modality to inform and aid the process of individual or group therapy. Rubin (1984) believes that “it is useful to have occasional mother-child sessions both early and late in treatment” (p.150). While Rubin (1984) recognizes that “unquestionably, the most important and influential dyad in a child’s life is himself and his mother” (p.150) and “mother and child are the most common and perhaps most frequently conflicted dyad within the family” (p.153), Rubin’s professional opinion regarding the use of dyadic sessions seems to be that it is one of many possible formats that can be used in order to help the child and the family.

It should be noted that Rubin had been including dyadic format in therapy (both as adjunctive and as principal mode of intervention) more than what transpires in her writings of this time. In the latest edition of *Child Art Therapy*, Rubin (2005) retroactively informs the reader that “over the years, I have often led short-term weekly joint groups for parents and children in a variety of settings” (p.214). Rubin also lectured about dyadic interventions (J. Rubin, personal communication, March 31, 2016) and it was a community-based dyadic work presented at Concordia University (circa 1993) that inspired Lucille Proulx in her development of *parent-child-dyad art therapy* method (L. Proulx, personal communication, August 2, 2014). In this latest edition of *Child Art Therapy* (2005), with the permission from the editor to aggregate more material, Rubin believed it necessary to “demystify the [dyadic] format” (J. Rubin, personal communication, March 31, 2016) in response to the many questions she was being asked during lectures and conferences. The latest edition (2005) thus includes vignettes from the 1974b article as well as new dyadic material.

Despite the fact that very little new material was published between 1975 and 1995, there are also more indications that art therapists were experimenting with the dyadic format in therapy and independently developing personal versions of dyad art therapy. The art therapist authors I

¹⁸ This responded more to the fact that the editor had not authorized a larger second edition (1984) of the book, rather than the author not having continued to use dyadic format in her intervention (J. Rubin, personal communication, 31 march, 2016).

present here are those for whom I have found written traces of the use of dyadic methods. There are certainly more.

Towards the end of this quiet period in dyad art therapy development, a few new authors published material regarding interventions using a dyadic set up without it being the main mode of therapy. Wix (1997) presents a case-study which focusses on the archetypal images of the mother-daughter relationship produced by a dyad during a three year period of intervention. While it seems that the original goal of therapy was to treat the dyad, individual sessions with the pre-adolescent daughter were more frequent because of the mother's recurrent incarcerations. Despite the imposed inconsistency of intervention, the goal of therapy concentrated on relational issues throughout the process.

As an experienced early childhood worker, Lucille Proulx had previously led parent-child groups. During her studies in art therapy at Concordia, Proulx had been inspired by a presentation of Judith Rubin who introduced community-based parent-child workshops about which she had not published at the time. For Proulx, this encounter served as validation for the previous dyadic work she had done and served as an example as to how to apply this modality within art therapy (L. Proulx, personal communication, August 2, 2014). Once Proulx graduated and became an art therapist in 1993, she wrote two articles that testify to her use of a dyadic frame of art therapy. In 1995, Proulx (Proulx & Minde, 1995) wrote about a father-toddler group and, in 2000, about a parent-toddler group. The articles provide descriptions of how the art-based parent-child interventions strengthen communication and the dyadic relationship. Proulx presents child lead and developmentally appropriate art activities as the locus of parent-child interaction. The art making process is also conceived as the container of this relational experience where the finished product made by the dyad is a symbol of this "pleasurable, close experience" (Proulx, 2000, p.5) and is taken home by the child. In both these articles, certain key elements of what Proulx will later present as a *parent-child-dyad art therapy* (2002, 2003) modality is present.

Finally, we turn to the North American art therapist Annette Shore. From her article published in 2000, we learn that Shore regularly used the dyadic format in working with children and that she had increasingly been doing so over a period of time. She writes: "I have become increasingly aware of the opportunities (and obligation) to use the parent as much as possible, and to recognize the integrity of the parent-child bond... Whether the bond is generally healthy

or tainted, it remains the soil within which the child exists and through which the child can receive nourishment” (p.14). Perhaps more than the case examples and her description of the mode of the intervention, Shore’s (2000) article is valuable in how it skillfully incorporates Winnicott’s notion of *parent consultation* into an art therapy framework and, by this, introduces a new theoretical base to dyadic art therapy, which previously had been grounded in family therapy.

At the same time, in Great Britain, similar professional trajectories were also being traced in dyadic art therapy. Penelope Hall is one such example who was practicing dyadic art therapy for quite some time before publishing about her experiences. Penelope Hall (2008) informs that the root of her development of dyadic art therapy technique began in the 1980s when she began to ask herself about the “feasibility of an art therapy approach for mothers with young children” (p.22). Hall (2008) began to co-run mother-baby painting weekend workshops that provided “valuable learning experience from which [Hall] was able to draw in the future” (p.22). From this first community dyadic art therapy intervention in the 1990s, Hall developed similar group instances in clinical settings and later in private practice.

Also in Israel, art therapist Yonathan Schur had also developed a dyadic art therapy intervention. Schur (2001) recounts how he gradually came to make use of dyadic art therapy:

For many years I used to treat children individually. I would meet the parents at regular intervals... for parent guidance. At times I asked myself what would occur if I were to allow both children and parents to express their worries and complaints in a joint art therapy session. In time the idea crystallized in my mind and I started to look during the introductory sessions for the families’ ability and readiness to work together. As this possibility became more apparent, I began to realize that, beneath the request to *fix* the child, there existed the desire to improve the relationship. (pp. 391-392)

Schur (2001) focusses on the three way communication in dyadic art therapy: that is he focusses on different parent-child-therapist communications, giving three case examples. Schur is instructive in discussing how to set up the best configuration in the therapy and how to modify this format as therapy progresses. While his case examples are predominantly dyadic and he uses the term *dyadic art therapy*, Schur (2001) presents it as a configuration within family art therapy and not a modality in itself. Indeed, Schur offers a foundational look on how the dyad configuration fits within family art therapy.

Birth of an art therapy modality

While since the mid-1990s dyadic format was receiving increasing attention by art therapists, I consider the beginning of the second wave of development to constitute its formal presentation as a modality of its own right. As described earlier, it is known that several art therapists were practicing dyadic art therapy. Lucille Proulx's (2002, 2003, 2004, 2005) publications (an article published in the *American Journal of Art Therapy*, shortly followed by a book, and finally a video example of dyadic art therapy method included in Judith A. Rubin's film *Art Therapy has many faces*), however, were the combined events that marked the beginning of dyadic art therapy's consolidation as a modality by officially communicated it to a larger public¹⁹. An indication of the importance of Proulx's book (2003) is that it is the work most cited by contemporary dyad art therapists thus indicating its major influence in the consolidation of dyadic art therapy.

The coming together of Proulx's dyadic art therapy method came progressively through her work at the Montreal Children's Hospital where Proulx completed her art therapy practicum and then was hired once she graduated in 1993. At the hospital, Proulx's dyadic work first concentrated on individual dyads but she eventually extended this experience to group settings. Central to Proulx's parent-child-dyad methods (2002, 2003, 2004, 2005) are the foundations in infant psychiatry and Attachment Theory. Proulx describes the context in which the initial dyadic group took place: "It started for economic reasons... we were looking for a financially feasible way... [to work] with parents and child. And my colleague and I... decided on the groups for parents and child... We made a proposal to the infant team and the psychiatrists agreed" (L. Proulx, personal communication, August 2, 2014).

The parent-infant group was evaluated as efficient in attaining the proposed goals for this population and so became a regular intervention set-up. The successful experience of the 0 to 3 year-old dyadic groups was then a base to try out with older preschoolers. Proulx recalls:

We were having a problem [with the 3 to 6 year olds], because... either the parents were anxious about letting their child go or the children were anxious about letting their parents go. So there was always a kerfuffle, and crying, and anxiety... But after we started the parent-child group in the infant team, I proposed... that we do a parent-child

art therapy session in the first half hour... This was agreed upon and we started... and it was so very successful. For some of the parents who... were anxious, the anxiety just melted away... In some cases the child was anxious... so then we would allow the mother to wait until the child was ready. (L. Proulx, personal communication, August 2, 2014)

Proulx continued tuning her dyadic methods which became increasingly defined within an attachment informed perspective. At the time, Attachment Theory was prominent and vigorously developing, and parent-child interventions were commonly practiced as they were logical practical application of theoretical principles (Stern, 1995). Proulx described her rapprochement to attachment-based techniques:

Once I was at Montreal Children's [Hospital], we had a lot of conferences and day workshops [and] that's when I got much further into Bowlby, Ainsworth, Main and Zeenah... Really, the focus of the infant team was on attachment... That's why the parent-child group came into being... We wanted to reinforce the attachment and we did not want to cause separation and anxiety by working with the parents alone or working with the children alone... Around the same time... Greenspan's work was coming to the surface at the 0 to 3 Institute in Washington DC and Doctor Mindy [director of the Infant team]... made a point of sending me to the conference in Washington so I could meet Greenspan and see what they were doing there... [This training] gave me the vocabulary I needed to talk about the [dyad] work I was doing. (L. Proulx, personal communication, August 2, 2014)

Before her book was published in 2003, Proulx was also very involved in promoting dyadic art therapy. She supervised several art therapy students completing their practicum at the Montreal Children's Hospital and also lead workshops for art therapists and other practitioners in Canada and in the United States (L. Proulx, personal communication, August 2, 2014). Proulx recalls that it was the great interest in dyadic art therapy that finally pressured her to publish: "I wrote the book because my friend Linda Chapman... was talking so much about my [work]... Linda was giving me credit for everything but... [others were] using my method; so I thought 'Gee, I'd better write the book!' So I wrote the book" (L. Proulx, personal communication, August 2, 2014).

¹⁹ It should also be noted that Proulx (Proulx & Minde, 1995; Proulx, 2000, 2002, 2003, 2005) is one of the first art therapists to focus her work on preschoolers, a population for which a frame is still currently needed in art

Although Proulx's (2003) book is clearly influenced by Attachment Theory, it does not overtly position itself as an attachment method. Proulx explains:

I don't really use the word *attachment*, I use the word *relationship* because in those days... if you did not do the Strange situation [Ainsworth et al., 1978]... you could not talk about what you were doing in terms of attachment... The hospital warned me... 'you might be in trouble if you start talking about attachment'. (L. Proulx, personal communication, August 2, 2014)

While this strict delineation of Attachment Theory described above is not of concern today, Proulx's experience sheds light on the context surrounding the difficulty of integrating Attachment Theory at the time.

Proulx has continued to develop her professional stance as an attachment-informed art therapist, a stance which can be witnessed in her latest publication (Proulx & Winkel, 2015) and is the focus of new book she is in the process of writing. What is novel about Proulx's (2002, 2003) approach to dyad art therapy is how she integrated contemporary theory, goals, and methods from infant psychiatry practiced where she worked into the field of art therapy. Similar to the way that art therapist Kwiatkowska (1978) developed family art therapy by joining the energetic movement of family therapy, Proulx (2002, 2003, 2004, 2005) was able to ride the wave of attachment informed infant interventions and, by this, she affirmed the modality of dyadic art therapy and helped define the increasingly travelled path of art therapists in the use of Attachment Theory.

Concluding thoughts

Since the publication of the seminal work of Proulx (2002, 2003), art therapists (such as Hall, 2008 and Rubin, 2005) who had been practicing with dyadic structures followed suit and began publishing about their dyadic art therapy experiences. Most impacting is that new authors writing about dyadic art therapy have dramatically increased the contributions in research, theoretical discussion, assessment, and intervention models. The presently available literature (see Appendix: Dyad art therapy readings) bears witness to the expansion, energy and diversity in the dyadic art therapy modality.

Despite the recent attention of dyadic art therapy, the purpose of this essay has been to step back and focus on the earlier development of the dyadic modality in art therapy. For this it

therapy (Metzi, 2015).

was first necessary to situate dyad art therapy and offer a frame from which to better understand its theoretical and practical evolution. I have argued that the inception of dyadic interventions is located in the eclectic theoretical influence of family therapy, Attachment Theory, Object Relations, and mother-child matrix theory. By presenting the various and overlapping origins that permitted the experimentation with dyadic practice and the theoretical schools that provided the orientations from which the modality gradually took form, I hope to have conveyed the multidisciplinary nature and rich history of dyadic art therapy.

The dyadic intervention has certain defining characteristics that are different from other forms of therapy. In this paper I have discussed the particularities of the dyadic client, conveyed the relational dynamic that this format brings forth and requires for the therapist, and brought to attention the voice of each actor within this intense and complex relational situation. Clearly, the multimodality of the parent-child client presents a complex situation which fits difficultly within traditional categorizations of interventions and calls for the expanding the habitual guidelines of art therapy practice.

After the context provided by the presentation of its theoretical grounding and defining characteristics of dyad intervention, this paper then investigated the gradual emergence of dyadic format in art therapy. By retrieving North American instances of art therapy centered on the dyadic client as witnessed in the practice of pioneering art therapists and their published contributions, this essay traced an evolution spanning from the 1970s to the turn of the 21st century. This period began with early experimentation of dyadic format in art therapy, culminated with the affirmation of dyadic art therapy as a separate modality, marking the present period of consolidation of dyad art therapy within the field.

It is interesting to see that early development of dyadic art therapy was facilitated through notions and format of family therapy. While a systemic understanding of the client continues to be intrinsic to dyadic interventions, dyad art therapy was always considered a subcategory of family structure. I believe that it is with the development of Attachment Theory and incorporations of Object Relations notions that the caregiver-child relationship itself could begin to be seen as the focal point, thus shifting the mire from the larger family system to the dyad itself.

In bridging art therapy with infant psychiatry, Lucille Proulx (2003) also was a testimony of a greater shift in art therapy. In 2006, art therapist Diane Waller wrote:

Increasingly art therapists are turning to Attachment Theory to explore early childhood relationships and their impact on subsequent behavior; and to family systems theory which seeks to make a change in the way that members interact rather than focusing on the child or children with *the problem* (p.281).

Waller's (2006) observation seem to be confirmed by Taylor Buck et al.'s (2013) survey that indicates that 74.4% of therapist working with children are greatly informed by Attachment Theory. The published literary contributions to dyadic art therapy in the last ten years (see Appendix: Dyad art therapy readings) are testimonies to this shift in theory and in practice. If these tendencies hold true, it would be expected that dyadic art therapy will continue to grow in popularity and become increasingly recognized, discussed, and included into art therapy identity. It is my personal wish that the province of Quebec, the region that enabled Lucille Proulx (2002, 2003, 2004, 2005) to develop her seminal work, will soon return to playing a key role in the development of the dyadic modality. I hope that the many art therapists that were trained by Proulx and inspired by her methods will contribute to the on-going dialogue and share their professional experiences of dyadic art therapy.

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